MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 938 01771

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Friendship | LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Friendship
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Wesley (Middle) Sewell (Last) Frizzell

4. DATE OF DEATH: (Month) 2 (Day) 5 (Year) 1949

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married | 8. DATE OF BIRTH Feb. 24 1874 | 9. AGE last birthday 74 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Frizzell | 14. MOTHER'S MAIDEN NAME Elma — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Roscoe Frizzell - West Friendship Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio Vascular disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Hemorrage

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948 to Feb 2, 1949 that I last saw the deceased alive on Feb 2, 1949, and that death occurred at 1 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
W. A. Barnes MD. | Sykesville Md | 2/6/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 2-7-49 | NAME OF CEMETERY OR CREMATORY Mt Kendree | LOCATION (City, town, or county) (State) West Friendship, Md.

DATE REC'D BY LOCAL REG. 2-6-49 | REGISTRAR'S SIGNATURE Alice M Hebb | 24. FUNERAL DIRECTOR C. Harry Ware | ADDRESS Sykesville Md.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH: COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
STREET ADDRESS (If rural give location) W. Frederick Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Thomas (Last) Ireland
4. DATE OF DEATH (Month) 2 (Day) 24 (Year) 1949

5. SEX M
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Jan. 1, 1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice Merchant
10b. KIND OF BUSINESS OR INDUSTRY Manf. Ice.
11. BIRTHPLACE (State or foreign country) Ellicott City Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Daniel Ireland
14. MOTHER'S MAIDEN NAME Hester Clifford.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lillian M Ireland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary embolism	10 min.
Antecedent cause(s)	(b) Volvulus,	6 wks
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arterio sclerotic Cardio Vascular disease

19a. DATE OF OPERATION Dec 2, 1948
19b. MAJOR FINDINGS OF OPERATION Volvulus, gangrene of intestine
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 24, 1949, to Feb 24, 1949, that I last saw the deceased alive on at no time, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE Alpha N Herbert M.D. (Degree or title) ADDRESS Ellicott City Md DATE SIGNED 2-24-49

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-28-49
NAME OF CEMETERY OR CREMATORY Western Star
LOCATION (City, town, or county) Catonsville (State) Md.

DATE REC'D BY LOCAL REG. Feb. 25, 1949
REGISTRAR'S SIGNATURE John B. Loughran. Per. B. E. L.
24. FUNERAL DIRECTOR F. V. Higinbothom ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

490 108 01773

CERTIFICATE OF DEATH

Reg. Dist. No. 19-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M — I — C

1. PLACE OF DEATH
COUNTY Howard Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) ALLEN (Last) MABE

4. DATE OF DEATH (Month) Feb. (Day) 7th. (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH 11/26/48

9. AGE last birthday yrs. If under 1 year Months 2 Days 12 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John B. Mabe

14. MOTHER'S MAIDEN NAME Bonnie Mavis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT John B. Mabe - Ellicott City Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar Pneumonia — Interval Between Onset and Death: 1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 7. 49, to Feb 7 49, that I last saw the deceased alive on At Noon, 19..., and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE Alpha M Herbert M.D. (Degree or title) ADDRESS Ellicott City Md DATE SIGNED 2-7-49

Deputy Medical Examiner Howard Co.

23. BURIAL, CREMATION, REMOVAL (Specify) Transportation DATE 2/7/49 NAME OF CEMETERY OR CREMATORY Mussell Family Cem. LOCATION (City, town, or county) Edison (State) Tenn.

DATE REC'D BY LOCAL REG. Feb. 7, 1949 REGISTRAR'S SIGNATURE John B. Loughman. Pro. B. E. L.

24. FUNERAL DIRECTOR Easton Sons - Ellicott City ADDRESS Md.

VS. A15

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FEB 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Florence
MARYLAND
LENGTH OF STAY (In this place): 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Florence
STREET ADDRESS (If rural give location): Rural -- Woodbine

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) W. (Last) MCDONALD

4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Feb. 22, 1884

9. AGE last birthday: 64 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James McDonald

14. MOTHER'S MAIDEN NAME: Frances J. Poole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Annie B. McDonald

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia by Strangulation — Interval between onset and death: 10 min

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Suicide

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Farm (CITY OR TOWN): Woodbine (COUNTY): Howard (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): 2 18 1949 2 p.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Hanging

22. I hereby certify that I attended the deceased from 2-18, 19 49, to 2-18, 19 49, that I last saw the deceased alive on At noon, 19..., and that death occurred at 2 p.m., from the causes and on the date stated above.

SIGNATURE: Alpha N. Herbert M.D. (Degree or title) ADDRESS: Ellicott City, Md. DATE SIGNED: 2-18-49

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE: 2-21-49
NAME OF CEMETERY OR CREMATORY: Jennings Chapel
LOCATION (City, town, or county) (State): Florence Md.

DATE REC'D BY LOCAL REG.: 2/21/49
REGISTRAR'S SIGNATURE: E. Pearl Mercer

24. FUNERAL DIRECTOR: C. M. Waltz ADDRESS: Winfield, Md.

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FEB 24 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Howard; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Highland; LENGTH OF STAY (in this place):	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Highland; STREET ADDRESS (If rural, give location):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	Gambrill	Parlette	Feb.	12	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
F	W	Widow	9-8-1873	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Catonsville Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Gambrill	Sarah Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	None	Winifred Parlette, Highland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Pulmonary edema due to	24 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Acute cardiac failure due to	24 hours
	(c)	Arteriosclerotic heart disease	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 1946, to 2/12, 1949, that I last saw the deceased alive on 2/12, 1949 and that death occurred at 9.45 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charles S. Whitaker	M.D.	Clarksville Rd.	2/14/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-14-49	Linthicum Chapel	Clarksville, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-15-49	Marie A. Whitaker	F.C. Higinbothom	

RECEIVED
FEB 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420 1 94a 01776

CERTIFICATE OF DEATH

Reg. Dist. No. 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge
LENGTH OF STAY (In this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge
STREET ADDRESS (If rural, give location) Washington Blvd.

3. NAME OF DECEASED (Type or Print) (First) SAMUEL (Middle) J. (Last) PEIRCE

4. DATE OF DEATH (Month) Feb (Day) 16 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH June 18, 1856

9. AGE last birthday 92 yrs. If under 1 year Months. Days. If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk

10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.

11. BIRTHPLACE (State or foreign country) Chester, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel C. Peirce

14. MOTHER'S MAIDEN NAME Martha Baldwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Mr. George A. Peirce Washington Blvd., Elkridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Sudden death - probably Coronary Embolism — Interval Between Onset and Death: few minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General arteriosclerosis - myocarditis — 10 yrs +

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ✓ | 19b. MAJOR FINDINGS OF OPERATION ✓ | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓ | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ✓ | (CITY OR TOWN) ✓ (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19.20, to Feb 16, 1949, that I last saw the deceased alive on Feb 10, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frederick V. Reuter M.D. ADDRESS 973 Medical Arts Bldg - Balto. DATE SIGNED 2-17-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 2/19/49 | NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REG. 2/18/49 | REGISTRAR'S SIGNATURE H.W. Hedrick DM

24. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

EVIDENCE FOR CHANGE OF AGE IS ON

CERTIFICATE OF DEATH

Registered No.

FILM No. G 11, MAR 15 1949

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH SHIPLEY

2. DATE OF DEATH Approx. 3 p.m. Feb. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland HOWARD COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ¼ mile north of Md. State Police Barracks "A", Elkridge, Md.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ~~Perrypoint~~ Unknown
D. STREET ADDRESS (If rural, give location) (Inmate of Perrypoint Hosp)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months	Days	If Under 24 Hours: Hours	Min.
~~MALE~~ Male	White	?	April 13, 1889	~~58~~ 59	10	14	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Draftsman	Retired	Maryland	U.S.A.

13. FATHER'S NAME J. C. Shipley

14. MOTHER'S MAIDEN NAME Louvina Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
Yes.	?	?

17. INFORMANT Louis Shipley ADDRESS Branchville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull — INTERVAL BETWEEN ONSET AND DEATH

~~DUE TO~~ Collapse of left lung

(B) Multiple fractures of ribs, left

902.5 ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

~~DUE TO~~

186a

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	road creek	¼ mi. north of Md. State Police

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ]	NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
Between 10 p.m. 2-26-49 and 6 a.m. 2-27-49			Barracks "A" Elkridge, Md. Missed footing and fell off roadway into creek

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE Earl [illegible] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 2-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	2-28-49	Savage Md.	Hyattsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Mar. 1 1949	Amanda Downey	Francis Leach Sons	Hyattsville

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 190

EVIDENCE FOR ADDITION OF AGE + BIRTH DATE IS ON FILM # 6119 - 3-1-49

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Howard, MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine; LENGTH OF STAY (In this place) Smonths; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland, COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) ALEX (Middle) (Last) SMITH

4. DATE OF DEATH: (Month) Feb. (Day) 19, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Not Known

8. DATE OF BIRTH: unknown 1889 apprx

9. AGE last birthday: -- yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Not known (If year, give war or dates of service)

16. SOCIAL SECURITY NO. ----------

17. INFORMANT: State Police

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Fracture of Cervical vertebrae

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pedestrian struck by automobile

(c)

INTERVAL BETWEEN ONSET AND DEATH: Inst

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Fracture of both legs below knees

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: --

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Street; (CITY OR TOWN) Poplar Springs; (COUNTY) Howard; (STATE) Md

TIME OF INJURY (Month) 2 (Day) 19 (Year) 1949 (Hour) 6:15 p.m.; INJURY OCCURRED While at Work ☐ Not While At work ☑; HOW DID INJURY OCCUR? Automobile Accident - victim was pedestrian

22. I hereby certify that I attended the deceased from 2-19, 1949, to 2-19, 1949, that I last saw the deceased alive on 2-19-49, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Upshur Herbert M D; ADDRESS Ellicott City Md; DATE SIGNED 2-19-49

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

25. BURIAL, CREMATION, REMOVAL (Specify): BURIAL; DATE 2-21-49; NAME OF CEMETERY OR CREMATORY Potters Field; LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. 2/20/49; REGISTRAR'S SIGNATURE E. Paul Spencer

24. FUNERAL DIRECTOR: C. M. Waltz, ADDRESS Winfield, Md.

VS. A15

RECEIVED
FEB 24 1949
BUREAU T. S.

01779

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 195

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY: Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel; LENGTH OF STAY (in this place): 25 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: North Laurel	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel; STREET ADDRESS (If rural give location): Washington Blvd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Myrtle	May	Ward	February	4	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	married	May 16 1887	61 yrs.	10	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Laurel, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Brown	Myrtle Featherstone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Joseph Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	5 yrs.
	(c) Bronchial Asthma	10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from July, 1937, to Feb 4, 1949, that I last saw the deceased alive on Feb 4, 1949 and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John M. Warren M.D.		2/6/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 7, 1949	Any Hill Cemetery	Laurel, Maryland

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2/6/49	Frank Shipley,	De Witt Donaldson, Laurel, Md.

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FEB 8 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01780

752

157a

Reg. Dist. No. 194

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1

VS. A15

1. PLACE OF DEATH: COUNTY: Howard — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Clarksville
LENGTH OF STAY (in this place): 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Columbia Pike 3 m. West

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: Prince Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hillside
STREET ADDRESS (If rural give location): 209 - 56 Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PATRICIA	ANN	WOOTEN	Feb	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Single	11/15/47	1 yrs.	2 25	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U S

13. FATHER'S NAME: Amos Monroe Wooten
14. MOTHER'S MAIDEN NAME: Agnes Mae Gressett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Amos M. Wooten

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Marasmus due to — 5 mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) Congenital internal hydrocephalus — 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1949, to Feb 12., 1949, that I last saw the deceased alive on Feb 12, 1949, and that death occurred at 7 00 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Charles S. Whitaker M.D. — Clarksville, Md. — 2/14/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/15/49	Cedar Hill	Prince Geo. Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-15-49	Marie A Whitaker	W.W. Chambers, 517 11th St. S.E. Wash, D.C.	

RECEIVED
FEB 17 1949
BUREAU V. S.